STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676450	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terra Bella Health and Wellness Suites	12262 Cityscape Ave Houston, TX 77047

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error rate was not five percent or greater for 2 residents (Resident #10 and Resident #3) of 6 residents observed for Medication Pass. -Resident #10 was administered 9 medications that were prescribed to Resident #107. -Surveyor intervention prevented Resident #3 from receiving one medication that was prescribed to Resident #103. -The medication pass observation yielded 10 errors of 27 opportunities and resulted in a 37% error rate. The failure placed residents at risk of having harmful effects from being administered the wrong medications. Findings included:Record review of the Face Sheet for Resident #10 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included cerebral infarction (stroke), left side hemiplegia (loss of use of the left side), diabetes type 2, hypertension (high blood pressure), and embolism and thrombosis (blood clot) of an unspecified artery.Record review of Resident #10's Care Plan dated 12/05/2024 revealed he had diagnoses of atherosclerosis (buildup of fats and cholesterol in arteries), hyperlipidemia (high cholesterol), and hypertension (high blood pressure). The Care Plan read, in part, .Administer meds as ordered.Record review of the Face Sheet for Resident #107 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included cerebral infarction (stroke), left side hemiplegia (loss of use of left side), hypertension (high blood pressure), heart disease, chronic kidney disease, and cognitive communication deficit (difficulty communicating).Record review of Resident #107's Care Plan dated 11/26/2024 revealed he had diagnoses of hypertension, hypercholesterolemia (high cholesterol), Deep Vein Thrombosis (blood clot), Atrial Fibrillation (heart arrythmias), and Congestive Heart Failure. The Care Plan read, in part, .Administer meds as ordered.Observation on 03/25/2026 at 08:09 a.m. revealed MA A in Hall 200, standing in front of Resident #10 and Resident #107's doorway. She had the Hall 200 Medication Aide Cart. MA A had a wrist style blood pressure (BP) cuff. She entered the room and obtained the blood pressure and pulse rate for Resident #107. Resident #107's BP was 192/108 mmHg and the pulse was 60 bpm. MA A had addressed Resident #107 and Resident #10 by their correct first names and the residents appeared to be familiar with MA A. Continued observation revealed MA A informed RN B and RN C, who were in the hallway, that Resident #107's BP was high. MA A returned to the room and obtained Resident #107's BP and pulse with a different BP cuff. The retake reflected BP 198/98 mmHg and pulse was 63 bpm. MA A informed the Surveyor that RN B and RN C would address Resident #107. Continued observation revealed MA A then obtained the BP and pulse of Resident #10, the roommate of Resident #107. The results were: BP 129/78 mmHg and pulse 65 bpm. Continued observation revealed MA A return to the Medication Cart in the hallway. MA A pulled up the orders for Resident #107. MA A showed the label for each medication as she dispensed them, and the Surveyor documented them. MA A dispensed the following medications:Aspirin 81 mg chewable 1 tabBumetanide (Diuretic) 1 mg (milligram) 1 tabCarvedilol (to treat high BP)12.5 mg 1 tabClonidine (to treat high BP) 0.1 mg 1 tabEliquis (blood thinner) 5 mg 1 tabHydralazine (to treat high BP) 50 mg 1 tabJardiance (to lower blood sugar) 10 mg 1 tabLexapro (antidepressant)5 mg 1 tabLosartan Potassium (to lower BP) 100 mg 1 tabAll of the medication ?bubble packs' shown to the Surveyor had Resident #107's name on them. MA A verbalized the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	number of tablets in the medication cup was 9. Continued observation revealed MA A re-enter the room and hand the medications to Resident #10. MA A said Here, _____ [Resident #107]. Resident #10 replied I'm _____ [Resident #10] and quickly placed all 9 medications in his mouth and swallowed them before the Surveyor could intervene. Resident #107, who was in the bed next to Resident #10, did not say anything. Observation and interview on 03/25/2026 at 8:23 a.m. revealed MA A returned to the medication cart. The Surveyor asked MA A whose medications were administered to Resident #10. MA A said they were Resident #10's medications. The Surveyor asked MA A to log on to the laptop and see whose medications were dispensed. When the computer screen appeared, the medication orders for Resident #107 were on the screen. MA A again said she had dispensed the medications for Resident #10.Observation and interview on 03/25/2026 at 08:26 a.m. revealed the Surveyor asked RN B to compare the list made by the Surveyor when MA A dispensed the medications she just administered to Resident #10. RN B compared the list with Resident #107's eMAR, which was still displayed on MA A's computer screen. RN B compared the list of medications written by the Surveyor with the Medication orders for Resident #107. She confirmed that Resident #10 had received Resident #107's medications. During the observation of MA A, Resident #107 did not receive any medications. Record review of the current physician orders for Resident #107 revealed the following (not comprehensive):ASA (aspirin) 81 mg (milligram), one by mouth dailyBumetanide 1 mg, one by mouth twice dailyCarvedilol 12.5 mg, one by mouth twice dailyClonidine Hydrochloride (HCl) 0.1 mg, one by mouth daily, with special instructions to administer if blood pressure is greater than 160/90 mmHgEliquis 5 mg, one tablet by mouth twice daily.Hydralazine 50 mg, one by mouth three times daily, hold if systolic blood pressure is less than 110 mmHg or diastolic blood pressure is less than 60 mmHg Jardiance 10 mg, one tablet by mouth daily.Lexapro 5 mg, one tablet by mouth dailyLosartan Potassium 100 mg, one by mouth daily, hold if systolic blood pressure is less than 110 mmHg or diastolic blood pressure is less than 60 mmHg The physician orders for Resident #107 were consistent with the nine medications administered to Resident #10.Record review of the current physician orders for Resident #10 revealed the following (not comprehensive):ASA 81 mg EC (enteric coated) one by mouth dailyClonidine HCl (to treat high blood pressure) 0.1 mg one tablet daily, hold if systolic blood pressure is less than 110 mmHg or diastolic blood pressure is less than 60 mmHgClopidogrel (to reduce chance of blood clots) 75 mg one tablet dailyDecubivite (vitamin) one tablet dailyHydrochlorothiazide (to treat high blood pressure) 50 mg one tablet daily, hold if systolic blood pressure is less than 110 mmHg or diastolic blood pressure is less than 60 mmHgToprol ER (to treat high blood pressure) 100, mg one tablet daily, hold if systolic blood pressure is less than 110 mmHg or diastolic blood pressure is less than 60 mmHg.Nifedipine ER (to treat high blood pressure) 90 mg one tablet daily.KCL (Potassium Chloride) 20 milliequivalents one tablet three times dailyTylenol 325 mg, two tablets by mouth twice daily.Verapamil (to treat high blood pressure) 120 mg one tablet daily, hold if systolic blood pressure is less than 110 mmHg or diastolic blood pressure is less than 60 mmHg.The physician orders for Resident #10 were not consistent with the nine medications administered to Resident #10.In an interview on 03/25/2026 at 08:31 a.m., RN B said she would call the doctor. In an interview on 03/25/2026 at 08:51 a.m. RN B said MA A had been relieved of the medication cart. She said the facility would initiate vital sign checks every 15 minutes. She said the facility called the doctor and the family. An in-service was provided to MA A.In an interview on 03/25/2026 at 12:05 p.m. Resident #10 said the staff have been checking on him frequently, obtaining his blood pressure. He said he was informed that he received the wrong medications. In an interview on 03/25/2026 at 12:08 p.m. the DON said she was aware Resident #10 received Resident #107's medications. She said the facility did a head-to toe assessment of Resident #10. The resident denied having nausea or emesis, and did not complain of pain or discomfort. She said the possible negative outcomes could have been a drop of blood pressure or blood sugar levels. There could possibly be gastrointestinal upset. In an interview on 03/25/2026 at 12:10 p.m. the Administrator said the resident's blood pressure could go up or down, and the resident could possibly die. In an interview (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 03/25/2026 at 2:20 p.m., the DON said the proper steps for the medication administration would have been prior to the administration the MA should have checked the five rights: right resident, right medication, right dose, right route, and right time. If giving BP medications, vital signs should have been obtained. After the medications were dispensed from the cart and the MA was back in the room, the resident's identity should have been verified again. Then the MA should have told the resident what medications she had, and asked the resident if he wanted to take all or some of the medications. Attempts to contact the physician on 03/25/2026 at 5:12 p.m. and again on 03/26/2026 at 09:40 a.m. were unsuccessful. A message to contact the Surveyor was provided. In an interview on 03/26/2026 at 09:45 a.m., the DON said she and the night supervisor conducted observation rounds with the nurses and medication aides to monitor medication administration. She said that on 03/25/2026 she did walking rounds with one of the nurses on the same hall as MA A, but not with MA A.Review of the competency checklist for MA A dated 08/27/2025 revealed she was to compare the resident's name with the Medication Administration Record (MAR).Record review of the Face Sheet for Resident #3 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included cerebral infarction (stroke), hypertension (high blood pressure), bipolar disorder, and seizures.Observation and interview on 03/26/2026 at 12:50 p.m. revealed LVN D was with a medication cart in front of room [ROOM NUMBER]. She said she was going to administer medications to Resident #3. LVN D retrieved two medication bubble pack cards from the cart. LVN D dispensed one tablet of Gabapentin 300 mg from the first card into a 30 cc cup. She set the card on the right side of the medication cart, face down. LVN D then dispensed one tablet of Tizanidine 4 mg from the second card into the 30 cc cup. She placed the second card on top of the first card, also face down. LVN D picked up both cards and started to place them in the medication cart. The Surveyor stopped her and asked which resident she was dispensing medications for. She said Resident _____ [Resident #3]. The Surveyor asked to see the medication card with the Gabapentin 300 mg tablets. LVN D presented the card. The Resident name on the card was Resident #103. LVN D said she knew the tablet of Gabapentin 300 mg was from a different resident than Resident #3. She said I was just trying to cover it. She said she knew she was not supposed to dispense medications from a different resident. In an interview via telephone on 03/26/2026 at 5:01 p.m., MA A said she did not have the computer mouse that she usually used, and thought she had closed out Resident #107's eMAR and had pulled up Resident #10's eMAR. She said the risk for administering the wrong medications could cause great harm or even death. Record review of the facility policy Pharmacy Policies and Procedures (revised 04/17/2024) read, in part, .1. The staff and practitioners shall strive to minimize potential for medication error by: Following The 8 Rights for administering medication:The Right Patient/Resident .